UTMB-GALVESTON PAGE: 1

PHYSICIAN ORDER SHEET - SESSION PRINT: 07/16/04

DISCHARGE STATUS: NONE

ROBERTSON ,RICKY **708320Q** **30001068644** Adm Date: 07/16/04

Attending: 06947 ANTWI MD, STEPHEN Pager: Svc/Team: ERT Room/Bed: ER ER 015 ET

Resident: Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

Intern: Wt: kg Ht: cm BSA:

Diagnosis: Sex: F Isol: N TRANSPORT: TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:

NKA-UNVERIFIED

DEP	DESCRIPTION	ORDER #
LAB	(ER) LITHIUM LEVEL VENOUS ONCE STAT START DT/TM: 07/16/04 01:10	19
	(ER) LACTIC ACID PLASMA VENOUS ONCE STAT START DT/TM: 07/16/04 01:10	20
	(ER) HEPATIC FUNCTION PANEL VENOUS ONCE STAT PANEL TESTS ORDERED: ALB,ALK PHOS,ALT,AST BILI BU/BC,TOT BILI,TOT PROT START DT/TM: 07/16/04 01:11	21

Sent 00 0115 hrs

------- Ordered By: 07674 MOVVA MBBS,SUNIL 191313 @ 07/16/04 01:09 33 ---------

Confidential: Medical Record Copy - Place in Patient's Chart

01:12 07/16/04 FROM H102,OESESOFA

10.4

DISCHARGE STATUS:

ROBERTSON ,RICKY **708320Q** **30001068644** Adm Date: 07/16/04

Attending: 06947 ANTWI MD, STEPHEN Pager: Svc/Team: ERT Room/Bed: ER ER 015 ET
Resident: Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966
Intern: Wt: kg Ht: cm BSA:
Diagnosis: Sex: F Isol: N **TRANSPORT:** **TDC #: 001172218**

ALLERGIES/CONTRAINDICATIONS:
NKA-UNVERIFIED

DEP	DESCRIPTION	ORDER #
	PHYSICIAN SHEET CONTINUED	
	(ER) ACETAMINOPHEN LEVEL VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	13
	(ER) AMMONIA PLASMA VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	14
	(ER) DRUG PANEL 3 SERUM VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	15
	(ER) KETONE SERUM VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	16
	(ER) SALICYLATE VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	17
	(ER) BLOOD GAS-ARTERIAL ACUTE ARTERIAL ONCE STAT START DT/TM: 07/16/04 00:34	18

------- Ordered By: 06947 ANTWI MD,STEPHEN 93795 @ 07/16/04 00:32 34 ---------

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00:34 07/16/04 FROM D119,OESES0FA

UTMB-GALVESTON PAGE: 1

PHYSICIAN ORDER SHEET - SESSION PRINT: 07/16/04

DISCHARGE STATUS:

ROBERTSON ,RICKY **708320Q** **30001068644** Adm Date: 07/16/04

Attending: 06947 ANTWI MD, STEPHEN Pager: Svc/Team: ERT Room/Bed: ER ER 015 ET

Resident: Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

Intern: Wt: kg Ht: cm BSA:

Diagnosis: Sex: F Isol: N TRANSPORT: TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:
NKA-UNVERIFIED

DEP	DESCRIPTION	ORDER #
LAB	(ER) TSH (THYROID STIMULATING VENOUS ONCE START DT/TM: 07/16/04 00:32	6
	(ER) T4 (THYROXINE, TOTAL) VENOUS ONCE START DT/TM: 07/16/04 00:32	7
	(ER) BASIC METABOLIC PANEL VENOUS ONCE STAT PANEL TESTS ORDERED: NA,K,CL,CO2,CA,GLU,CREAT,BUN START DT/TM: 07/16/04 00:34	1
	(ER) CBC - WITH DIFFERENTIAL VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	2
	(ER) MAGNESIUM SERUM VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	3
	(ER) PHOSPHORUS, SERUM VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	4
	(ER) ER URINE DRUG SCREEN 4 CLEAN CATCH/VOIDED ONCE STAT START DT/TM: 07/16/04 00:34	5
	(ER) PT (PROTHROMBIN TIME) VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	8
	(ER) APTT VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	9
	(ER) CKMB WITH TOTAL CK VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	10
	(ER) TROPONIN I QUANTITATIVE VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	11
	(ER) MAGNESIUM SERUM VENOUS ONCE STAT START DT/TM: 07/16/04 00:34	12

Sent 08 13

PHYSICIAN SHEET CONTINUED

Confidential: Medical Record Copy - Place in Patient's Chart

00:34 07/16/04 FROM D119,OESES0FA

10 10

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT 226 lb 90 kg	AGE 37y	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR! ALLERGIES: NKDA

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
7/16	RIV cardiac monitor foley 2L bolus DANTROLENE 90mg IV X 1 STAT pharm please send Dantrolene Stat to ER EAST STAT		
7/16/04 1245pm	Cefepime 2gm IVPB Stat Vancomycin 1gm IVPB STAT ✓ K LR 125cc/hr NS 125cc/hr		
7/16/04 1:35pm	Add Dantrolene		
7/16/04 1:50pm	Neurosurg 10mg IV X 1 dose STAT		
7/16/04 2:45pm	Dopamine gtt up Start at 10mcg/kg/min Titrate to MAP of 65		

IF PATIENT ID CARD OR LABEL IS MISSING, PLACE IN SPACE BELOW

30001068644

ROBERTSON ,RICKY

7083200

08/21/1966 CF

STAT LABEL

E

HSV:ERT

07/16/04R 00.30

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-3PT-Rev 1/00
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record
Yellow - Department
Pink - Physician

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

10.7

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR!
			ALLERGIES:

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
	2 Amp B. carb EKG 40 meq Potassium IV		

UTMB FORMS MGT: STRICTLY PROHIBITS CHANGES TO THIS FORM

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

Robertson Ricky
708320

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-3PT-Rev 1/00
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record
Yellow - Department
Pink - Physician

10.8

UTMB-GALVESTON PAGE: 1

PHYSICIAN ORDER SHEET - SESSION PRINT: 07/16/04

DISCHARGE STATUS: NONE

ROBERTSON ,RICKY **7083200** **30001068644** Adm Date: 07/16/04

Attending: 05464 BEARY MD,WILLIAM M Pager: Svc/Team: MPU MICU Room/Bed: J4A J4A 05 IA

Resident: 07674 MOVVA MBBS,SUNIL Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

Intern: Wt: 104. kg Ht: cm BSA:

Diagnosis: Sex: M Isol: N TRANSPORT: TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:
NKA-UNVERIFIED

DEP	DESCRIPTION	ORDER #
CON	CONSULT: FOOD AND NUTRITION - ASAP SEE COMMENTS	23

COMMENTS: POSITIVE SCREEN CONSULT: NUTRITIONAL RISK.OD PATIENT
********** FROM: Y73C KHEDERLARIAN RN , BERTHA
START DT/TM: 07/16/04 05:20

------- Ordered By: 05464 BEARY MD,WILLIAM M @ 07/16/04 05:19 31 ---------

Confidential: Medical Record Copy - Place in Patient's Chart

05:20 07/16/04 FROM MS01,OESES0FA

10 9

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR!
			ALLERGIES:

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
2/16/01 3:35pm	① Levophed drip : start 8mcg/min titrate to MAP ≥ 65		

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

7083200 ER CARD
ROBERTSON ,RICKY

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-3PT-Rev 1/00
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record
Yellow - Department
Pink - Physician

1010

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR!
			ALLERGIES:

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
0358			

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

7083200 IR CARD
ROBERTSON ,RICKY

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-3PT-Rev 1/00
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record
Yellow - Department
Pink - Physician

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

DISCHARGE STATUS: NONE

ROBERTSON ,RICKY **708320Q** **30001068644** Adm Date: 07/16/04

Attending: 05464 BEARY MD,WILLIAM M Pager: Svc/Team: MPU MICU Room/Bed: J4A J4A 05 IA
Resident: 07674 MOVVA MBBS,SUNIL Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966
Intern: 08171 WARTHAN MD,MOLLY MAE 207362 Wt: 104. kg Ht: cm BSA:
Diagnosis: Sex: M Isol: N TRANSPORT: TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:
NKA-UNVERIFIED

DEP	DESCRIPTION	ORDER #
ADM	ADMIT TO: SVC= MPU / TEAM= MICU ADMIT DT/TM: 07/16/04 03:22	24
CON	CONSULT: EEG/EVOKED POTENTIAL - STAT SEE COMMENTS COMMENTS: 37 Y.O. WM WITH DRUG OD (TCA) POSSIBLE SEPSIS IN POOR CONDITION. EVALUATE FOR POSSIBLE SEIZURES. START DT/TM: 07/16/04 09:18	25

------- Ordered By: 08171 WARTHAN MD,MOLLY MAE 207362 @ 07/16/04 09:17 07 ---------

Confidential: Medical Record Copy - Place in Patient's Chart

09:18 07/16/04 FROM R946,OESES0FA

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR!
	103.7	37	ALLERGIES: NKDA

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
6/7/16/04	Admit Pt to MICU, Dr. Berry		
6:30 AM	1° Drug overdose		
	2° Seizures		
	Condition: Poor		
	Nursing: VS q2h, neuro check q1 hr,		
	I/O, foley Als, A line, NG tube & charcoal lavage		
	Diet: NPO		
	CK, CK-MB, Trop x1 stat, Chem 10/60 stat, D dimer.		
	Labs: CK, CK-MB, Trop I q8 hrs, Chem 10/60		
	q 4 hrs, CBC w/ Diff stat,		
	Comprehensive metabolic panel stat		
	Lactic acid q 6 hrs. ABG stat		
	CBC w/ Diff q12 hrs.		
	BCx x2 now & in AM & with fever spikes		
	ABG q 6 hrs, Vancomycin level 12 hrs after 5th vancomycin dose		
	PT/PTT q12 hrs.		
	Pharmacy: Dopamine dil - titrate to MAP >60		
	Levophed dil - titrate to MAP >60		
	Protonix 40 mg iv qd		
	SQ heparin 5000 mg bid/tid		
	~~Vancomycin 1gm iv q12~~ Levofloxacin 500mg iv x1 stat.		
	~~Ceftazidime 1gm~~ 1/2 x NS @ 150cc/hr		
	with 2 amp HCO_3 in every L of iv fluids.		
	44 meq K Phos IVPB x1		
	Pulmo: vent setting:		
	PRVC PEEP 5 FiO_2 100% RR 16 Vt 500		
	O_2 for protocol		

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NO. 68711

MFG. BY MOORE UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
7083200 CMS 08-21-66
ROBERTSON, RICKY
30001068644 MPU
I

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-Rev 08/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

071604

ICU-

10.13

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR!
	103.7	37	ALLERGIES: NKDA

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
	Rad – CXR q AM		
	Ident – EKG q 6 hrs.		
	[signature] RN	[signature], MD 08171	
7/16/04 5:00Am	PT, PTT, fibrinogen, FDP x1 stat. D-dimer stat. Ampicillin 2 gm IV x 1 stat. Dexamethasone 10 mg IV q 6 hrs. Ceftriaxone 2 gm IV x 1 [signature] 7-16-04 0500 (MOVVA)		
7/16/04 6:00A	U/A, UCx, Una, Ucr [signature] RN 7-16-04 0600		
7/16/04 6:00Am	Stat CXR 1 view [signature] RN 7-16-04 0600 [signature] (MOVVA)		

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NO. 68711

MFG. BY MOORE UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
708320Q CMS 08-21-66
ROBERTSON, RICKY
30001068644 MPU
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071604

PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-Rev 08/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

10 14

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR! ALLERGIES:

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
7/16/04 6:30A	Vent chgs ↓ FiO2 to 65%		
	[signature] 0630 7-16-04 [signature] (Morvay)		
7-16-04 0638	120cc [illegible] [signature]		
7/16/04	PC/PS 15 cm H2O Automode		
7/16/04	Dantrolene 100mg IV X 1 STAT		
7/16/04	Noted [signature]		[signature], MD FAXED 7/16 AD 0800 0817
7/16/04	R/O Coag. test [illegible] test		
	Tylenol 650mg [illegible] x 1 [signature]		
	ASAP		
	D/C Ampicillin		
7/16/04	Noted [signature] [signature] (Morvay)		FAXED AD 7/16/04 1200
7/16/04 10:45	D/C Auto mode keep PC/PS 15		
	Amylase & Lipase from blood in lab.		FAXED AD 7/16/04 1200
	Repeat EKG. M Duvall		
7/16/04	Noted [signature]		

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NO. 68711

MFG. BY MOORE UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
70832C Q CMS 08-21-66
ROBERTSON, RICKY
30001068644 MPU
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PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-Rev 08/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

071604

Init.

☆ USE BALL POINT PEN ☆

AUTHORIZATION IS GIVEN FOR DISPENSING BY NON-PROPRIETARY NAME UNDER UTMB FORMULARY SYSTEM UNLESS OTHERWISE SPECIFIED.	WEIGHT	AGE	NOTE: ALL ORDERS MUST BE SIGNED BY PHYSICIANS. NURSES MUST ACKNOWLEDGE ORDERS WITH SIGNATURE, DATE AND HOUR! ALLERGIES:

DATE/HOUR	☆ ANTIMICROBIALS MUST BE ORDERED ON SPECIAL FORM 5350-A10 ☆	SIGNATURE	DATE/HR
7/16/04	Tylenol 650 mg p.o. x 1 STAT		
1215	FAXED (MOVVA)		
12:15PM 7/16/04 1215	Noted [signature] RN (MOVVA)	[signature]	1200
7/16/04	Dalteparin 2500 mg Dalteparin IV x 1	[signature]	
12:30PM 7/16/04 1300	Noted [signature] RN FAXED (MOVVA)	[signature]	

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NO. 68711

MFG. BY MOORE UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
7083200 CMS 08-21-66
ROBERTSON, RICKY
3000106864 4 MPU
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PHYSICIAN'S ORDER SHEET

Medical Record Form 5350-Rev 08/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

MICU-

07/16/04 ROBERTSON ,RICKY 708320Q 30001068644

INCLUSION CRITERIA: ALL ADULT PATIENTS WHO ARE EXPECTED TO BE BEDRIDDEN GREATER THAN 12 HOURS AND EXHIBIT RISK FACTORS FOR THE DEVELOPMENT OF DEEP VEIN THROMBOSIS.

EXCLUSION CRITERIA: HEPARIN THERAPY SHOULD NOT BE ADMINISTERED IN PATIENTS WITH A HISTORY OF BLEEDING DISORDERS(PEPTIC ULCER DISEASE, von WILLEBRAND'S DISEASE, HEMOPHILIA; HEPARIN ALLERGY OR ADVERSE REACTION; INTRACRANIAL DISEASE PROCESS.

RISK	SCORE	RISK	SCORE
AGE 40-60		OBESITY(>20% IDEAL BODY WEIGHT)	
AGE 61-70(SCORE 2)		PREVIOUS OR FUTURE IMMOBILITY (>72H)	
AGE > 70(SCORE 3)		PELVIC OR LONG BONE FRACTURE	
SURGERY TIME OVER 2H		SYMPTOMATIC VARICOSE VEINS	
SEVERE SEPSIS		H/O DVT OR PULMONARY EMBOLUS(SCORE 3)	
MI		PREGNANCY/POST-PARTUM LESS THAN 1 MONTH	
HI DOSE ESTROGEN USE		MALIGNANT DZ,(SCORE 2),NO SKIN CA	
MULT TRAUMA(SCORE2)		VENOUS STASIS DISEASE INCL EDEMA,	
STROKE		ULCER STASIS,SYMP VARICOSE VEINS	
INFLAM BOWEL DZ		CONGESTIVE HEART FAILURE	
PARALYSIS		CENTRAL VENOUS ACCESS(SCORE 0)	
SPINAL CORD INJURY		THROMBOPHILIA (SCORE 3)	

TOTAL RISK FACTOR SCORE 0
PT INCLUDED IN DVT PROPHYLAXIS PROTOCOL? NO
REASON IF EXCLUDED PT WILL NOT BE BEDRIDDEN >12H

NOTE: THE CLINICAL PRACTICE GUIDELINE/PROTOCOL IS MEANT TO SERVE AS A GUIDELINE FOR ROUTINE PATIENT CARE. WHEN THE CONDITION OF THE PATIENT WARRANTS, TREATMENT DECISIONS MUST BE DICTATED BY THE SKILL AND JUDGEMENT OF THE HEALTH CARE PROFESSIONAL.

Quality Management
The University of Texas Medical Branch Hospitals
Galveston, Texas
DEEP VEIN THROMBOSIS PROPHYLAXIS PROTOCOL
Original-Medical Record

1017

Time in Room ____ Name ____ UH # ____

Time of Initial Assessment: 00:24

HISTORY OF PRESENT ILLNESS:
Chief Complaint: AMS/Not [illegible]
32 y/o found down in his cell unresponsive at 9pm. Pt was last in his normal state of health at 7pm

☒ Hx Limited due to: ☒ Mental State
☐ Condition/Unresponsive

Location: ____

Quality: ☐ Constant ☐ Intermittent ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Other ____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Duration: ____ mins/hrs/days/wks/mos/yrs

Timing: ☐ Onset: ☐ Sudden ☐ Gradual

Context: Occurred while ____

Modifying Factors: Relieved/Worsened by
☐ Nothing ☐ Rest ☐ Exertion ☐ Food
☐ Position ____
☐ Other ____

Associated Signs and Symptoms:
☐ Nausea ☐ Vomiting ☐ SOB ☐ None
☐ Other ____

PAST MEDICAL HX: ☐ Non-Contributory ☐ HTN
☐ Diabetes ☐ CAD ☐ Malignancy
☐ Current meds Thorazine, [illegible]
☐ Other Psych Problems

FAMILY HX: ☒ Non-Contributory ☐ HTN
☐ Diabetes ☐ CAD ☐ Malignancy
☐ Other ____

SOCIAL HX: ☐ Non-Contributory
☐ Tobacco ____ ppd ____ pack yrs
☐ ETOH usage
☐ Drug
☐ Other TDCJ [illegible]

If patient ID card or label is unavailable, write date, pt name and UH# in space below

7083200 ER CARD
ROBERTSON ,RICKY

Allergies: ____
Age/Wt: ____

REVIEW OF SYSTEMS:
CONSTITUTIONAL: ☐ No Sx ☐ Weakness ☐ Fever ☐ Chills ☐ Other ____
EYES: ☐ No Sx ☐ Pain ☐ Vision Chg ☐ Other ____
ENT: ☐ No Sx ☐ Sore Throat ☐ Nasal Congestion ☐ Other:
CV: ☐ No Sx ☐ Chest Pain ☐ Palpitations ☐ Other ____
RESP: ☐ No Sx ☐ SOB ☐ Cough ☐ Other ____
GI: ☐ No Sx ☐ Abd Pain ☐ Nausea ☐ Vomiting ☐ Other ____
GU: ☐ No Sx ☐ Dysuria ☐ Hematuria ☐ Freq ☐ Incont ☐ Other ____
MUSCULOSKELETAL: ☐ No Sx ☐ Pain in ____ ☐ Swelling in ____ ☐ Other ____
SKIN: ☐ No ☐ Rash ☐ Other ____
NEURO: ☐ No Sx ☐ Headache ☐ Numbness ☐ Other ____
PSYCH: ☐ No Sx ☐ Depression ☐ Anxiety ☐ Other ____
ENDOCRINE: ☐ No Sx ☐ Weight gain/loss ____ lbs ☐ Other ____
HEMAT/LYMPH: ☐ No Sx ☐ Swollen Glands ☐ Other ____
ALLERGIC/IMMUNOL: ☐ No Sx ☐ Hives ☐ Other ____

☐ ROS/PFSH obtained by student/other
Student signature ____
☐ Reviewed by Faculty ☒ Performed by Faculty

PROCEDURES:
☐ Thrombolysis under physician direction/order
☐ Intubation by physician; approach ☐ OT ☐ NT
Venous access: ☐ periph ☐ central
☐ Laceration repair: Size ____ cms ☐ simple ☐ interm ☐ complex
Location ____
Desc ____ ☐ Splint

☐ Other/Re-evaluation ____

See Procedure Note ☐

EMERGENCY SERVICES
Physician Documentation Form

Medical Record Form 7005-11/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original With Red Bar — Medical Record
White Copy — Billing
Yellow — Emergency Department

MFG. BY Moore Wallace North America Inc.

UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

Name _____ UH # _____

PHYSICAL EXAMINATION:
(+ positive finding; – normal)
Positive finding requires a comment
☐ Revwd Nurse Note
BP ____ P ____ RR ____ T ____ O_2 Sat ____

⊞⊟ EYES _____

⊞⊟ ENT Unremarkable

⊞⊟ NECK _____

⊞⊟ RESPIRATORY (B) air entry & Bronchial Wheezes

⊞⊟ CV Tachy NSR

⊞⊟ ABDOMEN/GI Soft mild distension

⊞⊟ GU _____

⊞⊟ NEURO Unresponsive

⊞⊟ PSYCH _____

⊞⊟ MS/EXTREMITIES good tone

⊞⊟ SKIN _____

⊞⊟ HEM/LYMPH/IMM Nasal bleed

MEDICAL DECISION MAKING:
Additional Information obtained from: Notified
☐ PCP/Consultant _____ ☐Y ☐N
☐ Old Records
☐ Other _____

X-RAY: _____

EKG:
Diagnostic: _____
Non-diagnostic: _____
Chg from prior: ☐Y ☐N

LABS:
☐ Normal
☐ Normal except

FACULTY ATTESTATION (Confirm/Revise):
☑ RN triage note, medicines, allergies, ROS, PFS History reviewed

Pt & Responsive to Hypotensive Started on pressors x2

☑ Critical Care Time 60 mins Faculty time
(Time spent performing separately billable procedures is excluded.)

IMPRESSION/PLAN:

A) Unresponsive, Respiratory Failure

P) Admit to MICU

RESIDENT PRINT NAME/DR#	FACULTY PRINT NAME/DR#
RESIDENT SIGNATURE	FACULTY SIGNATURE
DATE/TIME	DATE/TIME 7/16/04
DISCHARGE TIME	DISCHARGE CONDITION

Page ____ of ____

OBSERVATIONS/SIGNATURE (PLEASE SIGN AND TIME EACH ENTRY):	TIME	PAIN	BP	PULSE	RR	TEMP	PULSEOX	INT.
0235) BP ↓ - Cont to make urine	0235		88/34	122	16	38.5	100	E
pulses palp all ext MD aware	0245		88/36	116	14	38.4	100	E
Sm Sld Bolus NS Twide	0250		84/36	122	2	38.5	100	E
open ——— E	0300		64/36	112	20	38.6	100	E
0245) 1L NS hung wide open	0305		63/22	112	24		100	E
TO (L) EJ ——— E	0310		63/22	112	24	38.2	100	E
0320) dop ↑ 15 mcg/Kg/min dose	0320		54/24	120	22		100	E
TV BP 64/26 map 34. Report	0340		76/30	115	32		100	E
called to MICU ——— E								

DIAGNOSTIC & TREATMENT ORDERS

TIME ENTERED	COMP. INT.	ORDERS WITH SIGNATURE
		0300) 2L of NS infused - cont
		gtt wide open - pulses unable palp.
		Foley patent et draining yellow
		color urine ——— E
		0305) BP 63/22 map (32) ↑ dopamine
		TO 20 mcg/Kg/min (at 68 gtt/
0320	E	hr) BP (L) Arm 66/26 map (36)
0330	E	0310) PT TDC record not wt 226 lb
0340	E	20 mcg/Kg/min = 77 mL/hour
0400	E	which correction was done — E
		0320) 2L NS hung wide open — E
		0335) Levo gtt ↑ TO 12 mcg/min E
		0350) Levo gtt ↑ 20 mcg/min E
		0400) Transported TO MICU E
		MD BP ↑ E Vasopressors E

SIGNATURE VERIFICATION	INITIALS
Tracy Ellen RN	E

☐ Continued

CONSULTS	SERVICE	DOCTOR	TIME CALLED	TIME ARRIVED

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

TDP3209 ER CARD
ROBERTSON, ANTONY

CONTINUATION PAGE
EMERGENCY SERVICES MEDICAL RECORD

Medical Record Form 7005B-Rev. 03/01
The University of Texas Medical Branch Hospitals
Galveston, Texas

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Pink - Emergency Department

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Hx: psych Allergies NKDA

Page 2 of ___

OBSERVATIONS/SIGNATURE (PLEASE SIGN AND TIME EACH ENTRY):	TIME	PAIN	BP	PULSE	RR	TEMP	PULSEOX	INT.
(0024) 30 y/o TDC inmate, found down	0029	intub	86/18	130	29		100	MR
@ 9pm, c̄ ↑ temp. on unit, intubated			126/				ems	MS
w/ TDC EMS, 7.0 tube R nare, initial BP	0036		94/30 126	96/36	16	38.9	100	MR
68/20, after 2500 cc fluid BP 108/38	0047							
on arrival to UTMB ER, 18G LEJ PTA	0110		112/34	127	26	38.4	100%	E
c̄ LR ↑ + 20 G R Hand PTA c̄ NG,	0120		138/50	124	30	38.2	100	E
bag #3+4 hanging @ this time. BBS	0130		126/46	124	27	38.3	100	E
per Elliot RN, ⊕ CO2 per RT, Dr Antri,	0155		139/58	125	18	38.4	98	MS
Dr Lilli @ bedside for eval. pt placed								

	DIAGNOSTIC & TREATMENT ORDERS		
	TIME ENTERED	COMP. INT.	ORDERS WITH SIGNATURE
on cardiac monx 3, on vent, 18G			
PIV to L hand x1 by A. Talbey RN	0033	MS	xray @ bedside
labs drawn + sent, 16 F foley c̄ temp	0038	MS	vent setting
probe placed by G. Elliot RN @			BPM-16 tidal vol 550
clear yellow urine return — MS			100% FiO2 PEEP 5
(0033) Roy PA @ bedside to place	0039	MS	2L bolus NS c̄ LR
central line. ET tube 1" from	0047	MS	125 cc/hr NS c̄ L
hub to nare — MR			per 20 G R Hand.
(0041) Order faxed to pharm — MR	0055	E	Vancomycin 1Gm IV
(0048) 2 ems 4 L bags fluid in — MR	0040	E	Cefepime 2gm IVPB
(0049) EJ saline locked — MR	0048	MS	Vecuronium 10mg IV
(0130) Dr Antri notified of P+ VS, instructed			
to hold Dantrolene — MR			
0137) pt becoming more movement			
awaiting CT Scan to head - 400ml			
urine o/p when Foley placed - 360ml urine now			
(0140) Pt eyes taped shut — MR			

	SIGNATURE VERIFICATION	INITIALS
(0155) Pt to CT c̄ RN + RT — MR		
(0207) Return to ST3 from CT no change in status — MR	M Stratton RN	MR
(0208) Awaiting MICU admit — MR	G Elliot RN	E

☐ Continued

CONSULTS	SERVICE	DOCTOR	TIME CALLED	TIME ARRIVED

3BS
18 LG

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

68/20 bag #3+4 108/38
130 NKDA
psych hx
18 L EJ LR
20 R hand NS
7.0 nasal
R nare
Sed.

30001068644 7083200
ROBERTSON, R...
ROBERTSON, R... 08/21/1966 C F
ER CARD
STAT LABL

CONTINUATION PAGE
EMERGENCY SERVICES MEDICAL RECORD

Medical Record Form 7005B-Rev. 03/01
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Galveston, Texas

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Page _____ of _____

OBSERVATIONS/SIGNATURE (PLEASE SIGN AND TIME EACH ENTRY):	TIME	PAIN	BP	PULSE	RR	TEMP	PULSEOX	INT.
	0318		78/30	110	30			CE
	0345		78/30					
	0352		114/38	120	32			E
	0400		118/46	126	32	37.6		E

DIAGNOSTIC & TREATMENT ORDERS

TIME ENTERED	COMP. INT.	ORDERS WITH SIGNATURE

SIGNATURE VERIFICATION	INITIALS
Tony Ellen	E

☐ Continued

CONSULTS	SERVICE	DOCTOR	TIME CALLED	TIME ARRIVED

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

CONTINUATION PAGE
EMERGENCY SERVICES MEDICAL RECORD

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703320 ER CARD
ROBERTSON ,RICKY

10.24

Date	Time	EMERGENCY SERVICES PROCEDURE NOTE
7/16/04	0030	Central line (L) femoral Em areas
		Site prepped c betadine and draped
		c sterile towels in usual fashion
		Vein isolated c one pass of needle and ... arm
		aspirated c difficulty. Site dilated and then vein cannulated
		c triple lumen catheter & secured c nylon suture x2
		Lt's x3 aspirated blood freely & flushed c NS
		no complications

Attestation: [illegible]

Disposition:

Resident Signature: [illegible] PC 7840

Supervising Faculty Doctor's Name and Number: Alvarez 6949

Supervising Faculty Doctor's Signature: [illegible]

S - Subjective O - Objective A - Assessment P - Plan (1) Diagnostic (2) Therapeutic (3) Patient Education

Please sign each entry with status.

3000106B644 7083200

ROBERTSON, RICKY

08/21/1956 C F

STAT UBL

E

07/16/04 0.3

PROCEDURE NOTE
CONTINUATION PAGE
EMERGENCY SERVICES MEDICAL RECORD

Medical Record Form 7005-104-10/01
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record
Yellow - Billing
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10 23

7/16/04 RAN H&P

3:43 AM

CC: unresponsive

HPI: 39yo WM with PMH of bipolar disorder, borderline personality disorder and polysubstance abuse, presented to the ER from TDC after being found unresponsive in TDC at 22:10 PM (7/15/04), with empty store and axillary temp 108, HR 100 98/60 O2 sat 73% and intubated 2° to hypoxia. In the ER pt was unresponsive to pain with b fixed dilated pupils with HR 130 86/18 100% O2 sat on 40% FiO2. Pt had -ve CT head and was volume resuscitated with Ringer's and NS. Pt had +ve TCA levels with a noQRS prolongation and was started on NaHCO3. Pt then developed severe hypotension with MAP 20-30 and was started on dopamine & levophed to titrate MAP to 60 and was transferred to the floor for further mgmt. Pt started on empiric cefepime 2gm & vancomycin 1gm after obtaining BCx.

PMH: Bipolar disorder with depression

SH: TDC inmate, PMH of ETOH & Tob use

FH: NC

ROS: unable to obtain

OE: VS: HR 125, BP 118/39 (on pressors), T-37.3, O2 sat 94% on 40% FiO2

GE: pt unresponsive

neck: supple

HEENT: PERRL with nasally intubated

pupils fixed & dilated

CVS: S1S2 (+) bradycardia (+), no murmurs

RS: BBS ant on (R) side inflammatory region

Abd: soft, ND, NT

Ext: ± edema excoriations

Skin: ± linear lesions on (R) hand & forearm

Neuro: -ve gag, -ve response to pain

Extensor posturing (+)

Meds:

Lithium Carbonate 600 mg bid

Chlorpromazine 100 mg bid

& Benztropine 2 mg bid

Amlodipine 100 mg bid

Nortriptyline 75 mg @ PM

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

Roberts, Ricky

708320 a

HISTORY AND PHYSICAL EXAMINATION
(Not to be used for Progress Notes)

Medical Record Form 5100-Rev. 11/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68530

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D-24

G 87.37

Lab :- 17.2 > 12.8 < 78   137 | 111 | 24 < 87 / 3.2 | 20 | 2.38

PT 19.8   PTT 50   AGAP 6   7.6 / 0.8 / 1.8

NH_3 - 17   Lactic Acid 5.3

Lithium 1.4   Acetaminophen < 10   Salicylate < 10

Benzo, Barb - ve

TCA 660 ↑

7.35 30 170 16

CT head - ve acute

CXR - Patchy opacities in (R) mid & lower lung.

EKG: Sinus tachycardia.

A/P (i) AMS / Hypotension :- 39 yo WM with ~~no~~ sign PMH of bipolar disorder, found unresponsive in TDC unit S/P intubation, now with profound hypotension and unresponsiveness. Pt with fever, ∅ neck stiffness -ve Kernigs (B) Bz. ~~DD include drug overdose~~ Pt c̄ -ve CT head, ↑ WBC count, normal anion gap, mild non gap metabolic acidosis, ↑ lactic acid level, coagulopathic and with ↑ TCA levels. DD include drug overdosage (TCA) vs meningitis vs sepsis (2° to CAP) vs MI vs PE. Pt now with profound hypotension on dopamine & levophed. will obtain BC, follow pH & lactate levels. Continue iv fluids, alkalinization, and Ab. (vancomycin, levofloxacin, ceftazidime ceftriaxone). Pt with APACHE II score 33. will consider Xigris. ~~Start pt on~~ will obtain cardiac enzymes & D-Dimer. Start lovenox 100 mg SQ q12 hrs. will obtain DIC panel.

~~(ii) Bipolar disorder: Pt with bipolar disorder c̄ depressive features. Drug issues addressed~~

(ii) Respiratory failure: Likely 2° to drug overdose vs sepsis. Continue mechanical ventilation & ABG. will add lovenox after DIC panel & D Dimer.

(iii) Hypotension: Likely 2° to drug overdose vs sepsis vs meningitis. Continue fluid & pressor support. Pt given 6L fluids in ER

SECTION I Must be completed within the 1st hour of admission to inpatient unit or at point of entry as defined by policy.

GENERAL INFORMATION

Date: 7-16-04 Time: 0420 of Admission

Admitted from:
- ☐ Home
- ☑ ER
- ☐ MD Office/Clinic
- ☐ Nursing Home
- ☐ Other:

Primary Informant:
- ☐ Patient
- ☐ Family Member:
- ☒ Other: Pt. Unresponsive

Initial Vital Signs:
T 99.5 P 121 R 22 B/P 83/28 ☐ Rt. Arm ☑ Lt. Arm
Ht ____ Wt In KG 103.7
HC ____ (Neonatal and Pediatric patients under age 2 only)

Allergies: ☐ Yes ☐ No ☑ NKA
- Medications:
- Reaction:
- Foods:
- Reaction:
- Latex:
- Reaction:
- Other:
- Reaction:

Allergy bracelet applied: ☐ Yes ☐ N/A Initials ____
Name Band applied by: Initials (R)
CC/Reason for Hospitalization (state in patients own words):
Unknown, pt unresponsive

Primary Language:
☐ Speak ☐ Read ☐ Write
Highest Level of Education:
- ☐ Elementary-grade:
- ☐ Junior High-grade:
- ☐ High School-grade:
- ☐ College:

Occupation: Pt Unresponsive

Age: 37
- ☐ Pediatric Patient (Refer to Pediatric age-specific assessment addendum)
- ☐ OB (Refer to OB triage record)
- ☐ Psychiatric Patient (Refer to Psychiatric assessment addendum)

Emergency Contact
Name: Beverly Sisty 713 784 8845
Relationship: Next of Kin
Home #: 713 784 8845 Work #:
Mobile #: Pager:

Completed by: Initials: (R) Date: 7-16-04 Time: 0420

PHYSICIAN NOTIFIED ON ADMISSION

Name of Physician Notified: Dr. Mowa by (R) Date 7-16-04 Time 0420

ADVANCE DIRECTIVES AND GUARDIANSHIP

Advance Directives (Not required for pediatric patients) Pt. Unresponsive
Does the patient have:
☐ Yes ☐ No Directive to Physician (Living Will) If Yes, document intent:
☐ Yes ☐ No Out of Hospital DNR ☐ Yes ☐ No Medical Power of Attorney for Healthcare. If yes, who
Name Phone Number
If yes to any of the above, copy of document provided? ☐ Yes ☐ No If no, instructed to provide document? ☐ Yes ☐ No
Does the patient wish additional information/forms? ☐ Yes ☐ No
Patient/Family given Advance Directive Brochure by
Request for additional information/forms referred to by
Guardianship
Does the patient have a Power of Attorney other than Healthcare? ☐ Yes ☐ No
If so, who Phone
Does the patient have a legal guardian? ☐ Yes ☐ No
If so, who Phone

DISPOSITION OF VALUABLES

UTMB Hospitals will not assume responsibility for lost or damaged valuables, clothing or personal items kept in the patient's possession. Valuables may be deposited in the Cashier's Office for safekeeping upon patient/family request or identified need.

☐ No valuables present upon arrival to unit Comments
Hospital Policy explained by (R) Date: 7-16-04 Time: 0420
Patient or Family Representative Signature: Pt. Unresponsive Date: Time:

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
7083200 CMS 08-21-66
ROBERTSON ,RICKY
300010688644 MPU
I

INTERDISCIPLINARY ADMISSION ASSESSMENT

Note All Actual or Potential Health Care Concerns on the Interdisciplinary Plan of Care

Medical Record Form 5090-Rev. 8/2003
The University of Texas Medical Branch Hospitals
Galveston, Texas

MICU-

07604

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68503

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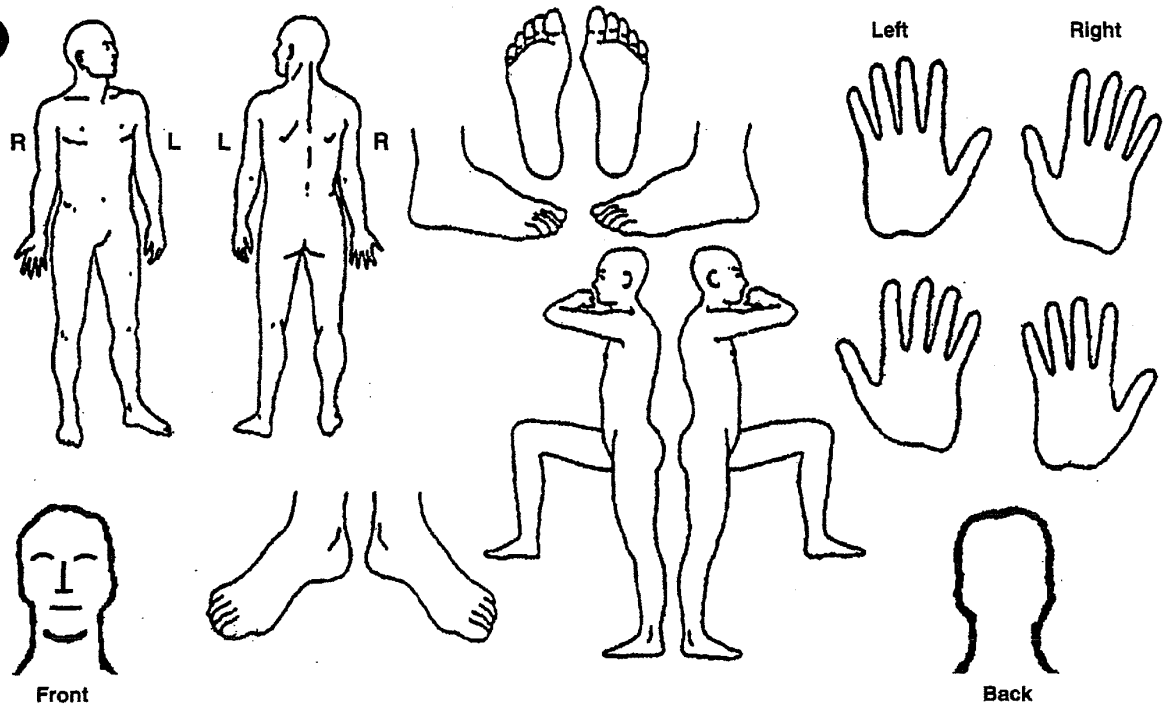
BODY DIAGRAM



Legend: Wound(s) = W Pain = P IV(s) = X

(Use subscripts if more than one site, i.e. W1, W2, etc.)

Indicate area and shape of any wound, lesion, burns, trauma, etc. in appropriate place on the above figures. Number each and describe below (what it is, size, color, discharge, odor, inflammation, etc.)

1 [illegible]
2
3
4
5
6
7
8
9
10

Completed by: Initials: _____ Date: _____ Time _____

SIGNATURES

Note All Actual or Potential Health Care Concerns on the Interdisciplinary Plan of Care. Refer any unusual and/or unexpected findings to physician.

Initials	Signature	Initials	Signature
[illegible]	[illegible]		

PAIN ASSESSMENT

A. Are you currently experiencing pain? ☐ Yes ☐ No If yes, complete 1-11.

1. Do you have pain in more than one location? ☐ Yes ☐ No
2. Location: A _____ B Pt w/ resp C _____
3. Intensity: Scale used _____ Rating _____
4. Quality (describe pain): _____
5. Onset/Duration: _____
6. Current Treatment: A _____ B _____ C _____
7. Satisfied with treatment? ☐ Yes ☐ No If no, explain _____
8. What relieves the pain? _____
9. What aggravates the pain? _____
10. What effect does the pain have on your functioning or quality of life? _____
11. What factors are associated with the pain? (N/V, dizzy, etc.): _____

B. Do you have any ongoing (chronic) painful conditions? ☐ Yes ☐ No If yes, complete 1-7.

1. Describe: _____
2. What effect does the pain have on your functioning or quality of life? _____
3. Is there anything we need to do to continue your current pain management program while you are in the hospital? _____
4. What relieves the pain? _____
5. What aggravates the pain? _____
6. What factors are associated with the pain? (N/V, dizzy, etc.): _____
7. Comfort goal: _____

C. Do you expect as a result of this admission that pain may be a problem for you? ☐ Yes ☐ No

Comfort goal set: _____ Comfort goal documented in plan of care? ☐ Yes ☐ No

Identified needs reported to: Physician _____ Date _____ Time _____

BRADEN SCALE

					Score
Sensory Perception	1 Completely Limited	2 Very Limited	3 Slightly Limited	4 No Impairment	1
Moisture	1 Constantly Moist	2 Very Moist	3 Occasionally Moist	4 Rarely Moist	3
Activity	1 Bedfast	2 Chair fast	3 Walks Occasionally	4 Walks Frequently	1
Mobility	1 Completely Mobile	2 Very Limited	3 Slightly Impaired	4 No Limitations	1
Nutrition	1 Very Poor	2 Probably Inadequate	3 Adequate	4 Excellent	1
Friction & Shear	1 Problem	2 Potential Problem	3 No Apparent Problem		1
				Total Score	8

A score of 18 or less requires referral to Plan of Care.

Completed by: Initials: IN Date: 7-16-04 Time: 0420

FALL PREVENTION ASSESSMENT

FALL PREVENTION ASSESSMENT: ✓ each risk factor present for this patient

- ☐ Age over 75
- ☑ Currently in the ICU
- ☐ Agitation/confusion/impaired memory/ impaired judgement/delirium/dementia
- ☐ ETOH abuse/withdrawal
- ☑ Unable or unwilling to follow directions
- ☐ Prior history of falls
- ☐ Dizziness, vertigo
- ☐ Frequent need to toilet/incontinence
- ☐ Orthostasis/hypovolemia

Other

- ☐ _____
- ☐ _____

If ANY of the above boxes are ✓'d, (in behavioral medicine, any two boxes) this patient is *at risk* for falls. The FALL PREVENTION PLAN OF CARE MUST BE IMPLEMENTED (available on POE and frequently used forms)

- ☐ Anesthesia in past 24 hours
- ☐ Anticonvulsants/antidepressants/tranquilizers/hypnotics/sedatives
- ☐ Antihypertensives/diuretics/laxatives
- ☐ Eye drops
- ☐ Depression
- ☐ Muscle weakness or paralysis
- ☑ Restricted by tubing/equipment (IV, NGT, Foley, etc)
- ☐ Unsteady galt/Uses cane or walker/Requires assistance for ambulating
- ☐ History of seizures/neurological diagnosis
- ☐ Uncorrected poor vision
- ☐ Decreased hearing
- ☐ Decreased sensation
- ☐ Communication impairment

Other

- ☐ _____
- ☐ _____

If TWO OR MORE of the above boxes are ✓'d (in behavioral medicine, any three boxes) this patient is *at risk* for falls. The FALL PREVENTION PLAN OF CARE MUST BE IMPLEMENTED (available on POE and frequently used forms)

☐ Patient not at risk for falls Assessed by: _____ RN Date: _____ Time: 1016

SECTION II To be completed within twelve (12) hours of admission to inpatient unit or at point of entry as defined by policy.

PAST MEDICAL HISTORY

Previous illness, injuries (indicate year): _____

Previous hospitalizations/surgeries (indicate year): Pt Unresponsive

Indicate with a (✓) if the patient or patient's family has a history of:

	Pt	Family		Pt	Family		Pt	Family		Pt	Family		Pt	Family
Diabetes	☐	☐	Tuberculosis	☐	☐	Pacemaker	☐	☐	Night Sweats	☐	☐	Seizures	☐	☐
Stroke	☐	☐	Stomach/intestinal	☐	☐	Fainting/Dizzy Spells	☐	☐	Hypertension	☐	☐	Thyroid Disorder	☐	☐
Rheumatic Disease	☐	☐	Urinary Problems	☐	☐	Liver Disease	☐	☐	Lung Disease	☐	☐	Bleeding/Clotting	☐	☐
Hepatitis	☐	☐	Heart Disease/Attack	☐	☐	GYN Problems	☐	☐	Asthma	☐	☐	Other	☐	☐
HIV/AIDS Positive	☐	☐	Chest Pain	☐	☐	Psychiatric	☐	☐	Cancer	☐	☐			

Pertinent Information related to history: Pt. Unresponsive

Has the patient had exposure to measles or chicken pox within the last 21 days? ☐ Yes ☐ No

Has the patient had a blood transfusion? ☐ Yes ☐ No If yes, did the patient have a reaction to the transfusion? ☐ Yes ☐ No

Has the patient a history of:

Drug Use? ☐ Yes ☐ No If yes, describe _____

Alcohol Use? ☐ Yes ☐ No If yes, describe _____

Tobacco use (includes dipping)? ☐ Yes ☐ No If yes, how many packs per day? _____

Current Medications (include over the counter medications, herbal supplements, diet aids and vitamins)

Is the patient on any research medications? ☐ Yes ☐ No If yes, list below.

Disposition of medication _____

Medication Name	Amount	How often
Unknown		

FUNCTIONAL INFORMATION

HEARING SCREEN

Does the patient have any of the following:

☐ Yes ☐ No Trouble hearing ☐ Yes ☐ No Patient/family feels patient may have a hearing loss

☐ Yes ☐ No Difficulty following spoken instructions

SPEECH SCREEN

Pt. Unresponsive

Does the patient have any of the following:

☐ Yes ☐ No Patient can communicate needs

☐ Yes ☐ No Patient coughs or chokes when eating or drinking

ACTIVITY SCREEN

Does the patient have difficulty completing any of the following activities alone?

☐ Yes ☐ No Bathing ☐ Yes ☐ No Dressing/undressing ☐ Yes ☐ No Toileting

☐ Yes ☐ No Feeding ☐ Yes ☐ No Work duties ☐ Yes ☐ No Stair climbing

☐ Yes ☐ No Walking ☐ Yes ☐ No Housework

SENSORY/COMMUNICATION SCREEN

☐ Difficulty with vision, taste, smell, or speech? ☐ Yes ☐ No

Exceptions: _____

Any yes response to above screens requires Physician notification.

☐ Yes ☐ No Glasses. If yes, location _____ ☐ Yes ☐ No Contacts. If yes, location _____

☐ Yes ☐ No Hearing aid. If yes, location _____ ☐ Yes ☐ No Dentures. If yes, location _____

Physician notified by: _____ Date: _____ Time: _____ Method: _____

10.74

NUTRITION SCREEN

Does the patient have any of the following:

☐ Yes ☐ No **Unplanned** weight loss (> 10 lbs/month)
☐ Yes ☐ No Severe food allergies/intolerance/avoidance
☐ Yes ☐ No Greater than 3 days of vomiting/diarrhea
☐ Yes ☐ No Receiving TPN/Tube feedings/supplements
☐ Yes ☐ No Does not understand or cannot follow special diet
☐ Yes ☐ No Inadequate growth/weight
☐ Yes ☐ No Chewing/swallowing difficulties
☐ Yes ☐ No Religious dietary considerations
☐ Multidisciplinary Protocol (includes Nutrition Assessment)

Any yes response requires a nutrition consult. Consult submitted by RKW Date 7-16-04 Time 0420

SPIRITUAL/CULTURAL SCREEN

Religious preference (If patient does not wish to discuss, do not continue): _____

Would you like to see a clergy? ☐ Yes ☐ No UNKnown

Will the patient's spiritual/cultural beliefs or practice impact medical treatment? ☐ Yes ☐ No If yes, describe _____

Does the patient have cultural or spiritual concerns or items/resources they require during hospitalization?

☐ Yes ☐ No If yes, list: _____

If yes is checked for any item, consult with Pastoral Care. Consult submitted by _____ Date _____ Time _____

ABUSE/NEGLECT SCREEN

No signs of abuse or neglect (abnormal *bruises, fractures/injuries not consistent with trauma described, bite marks, burns, malnutrition, dehydration, pressure sores, chronic poor hygiene, repetitive falls, contractures, fear of caregivers).* No exceptions ☑.

Exceptions: _____

Any exceptions require a consult with social services. Consult submitted by _____ Date _____ Time _____

CASE MANAGER/DISCHARGE PLANNING SCREEN

Not applicable for TDJC patient except OB

Where does the patient plan to go upon discharge? _____

If needed, is there someone available to assist the patient when discharged? ☐ Yes ☐ No

If yes, who? (Name and phone number) _____

Who will provide transportation to take the patient home? (Name and phone number) _____

How much notice will they need? _____ Are there times of day they cannot pick the patient up? _____

Is the patient currently using medical equipment at home: ☐ None ☐ Walker ☐ Wheelchair ☐ O_2 ☐ Other _____

Was the patient receiving home health care services prior to admission? ☐ Yes ☐ No

If yes, name of agency _____

Social Work and Discharge Planning Considerations

Check all that apply ☐ Transportation difficulties ☐ Admitted from long term care facility ☐ Need for temporary guardianship
☐ Home mobility problems (stairs) ☐ Frail or ADL dependent and living alone ☐ Medical non-compliance ☐ Failure to thrive
☐ Suspected or confirmed substance abuse ☐ Potential fetal demise ☐ Pregnant and under 17 ☐ Planned infant adoption
☐ No permanent housing/place to go after discharge ☐ Catastrophic illness ☐ TDJC offender that will deliver this admission
☐ Multidisciplinary Protocol (includes Social Work Assessment)

Any check requires Social Work Consult by whom _____ Date _____ Time _____

OTHER

Is there anything else that the patient could tell us that would help us meet the patients needs?

Additional comments:

10.30

CURRENT REVIEW OF HEALTH STATUS

Must be completed by a Registered Nurse within 12 hours of arrival

The following parameters will be considered normal. Normal findings will be indicated by checking the No Exceptions box. Abnormal finding will be described in the exceptions. Parameters unable to be assessed will be indicated by drawing one line through the parameter.

Cardiovascular: Regular apical pulse. No chest pain. No peripheral edema. Peripheral pulses present in all extremities. Extremities warm and color within patient norm. No calf tenderness. **For Infants:** No bounding pulses. No murmurs.
☐ No exceptions ☑ See ICU Flow Sheet for Exceptions.
Exceptions: _____

Respiratory: Respirations regular and unlabored. Nail beds and mucous membranes pink. Breath sounds clear and equal bilaterally. Cough absent. No sputum. ☐ No exceptions. ☑ See ICU Flow Sheet for Exceptions.
Exceptions: NWL Lungs Dry, Cap refill 3

Breasts: No patient report of lumps, nipple retraction, discharge or bleeding from nipples, or pain. ☐ No exceptions.
Last mammogram _____
Exceptions: N/A

Integumentary: Skin warm, dry and intact. Skin color within patient's norm. No petechiae or ecchymosis.
☐ No exceptions. If wound(s) present, indicate location on body diagram. ☐ See ICU Flow Sheet for exceptions.
Exceptions: Cool to the touch

Gastrointestinal: Abdomen soft, round. No guarding or tenderness. Positive bowel sounds all quads. No nausea, vomiting, diarrhea or constipation. No ostomies. Continent of stool. ☑ No exceptions. ☐ See ICU Flow Sheet for exceptions.
Exceptions: _____

Last bowel movement Unknown
Psychological/Emotional/Behavioral: Cooperative. Behavior appropriate for age and situation. Verbalizes adequate sleep. Denies anxiety. **For Infants:** not fussy, agitated, or irritable. **For Children:** easily consoled, positive response to distraction techniques.
☐ No exceptions.
Exceptions: Pt. Unresponsive

Neurological: Alert and oriented x 4. Active ROM all extremities with symmetry of strength. Verbalization clear and understandable. Swallow intact. No evidence of seizure activity. **For Infants:** neonatal reflexes appropriate to age.
☐ No exceptions. ☑ See ICU Flow Sheet for exceptions.
Exceptions: Pt unresponsive

Genitourinary: Urine clear, yellow or amber. No c/o dysuria, frequency, urgency or retention. Continent of urine. Bladder not distended. No catheters, drain or ostomies. ☑ No exceptions.
Females: Reports no unusual vaginal bleeding or dysmenorrhea.
Gravida _____ **Para** _____ **LMP** _____ **Last Pap Smear** _____
Exceptions: _____

Males: Reports no genital swelling, masses, or prostate problems. ☑ No exceptions.
Exceptions: _____

Hydration Status: Skin turgor elastic, mucous membranes moist. **For Infants:** Anterior and posterior fontaneles soft and flat.
☑ No exceptions.
Exceptions: _____

Patient Health Care Concern ☐ Actual ☑ Potential	Date Resolved	Initials	Date Identified	Initials
Impairment of skin integrity			7-16-04	

Patient Goal/Measurable Outcome	Date Identified	Initials
1. Patient will have no skin breakdown	7-16-04	
2. Patient will have no further skin breakdown if pre-existing	↓	↓
3.		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Assess skin upon admission then O/Shift & prn	7-16-04					
2. Keep skin clean & dry, reposition Q 2 hours	↓	↓				
3. Perform Braden Scale assessment QOD						
4. OOB as indicated if ordered						
5. Monitor I&O and nutritional intake						
6. Avoid Pressure from cables, tubings, etc.						
7. Avoid shearing injury by lifting rather than pulling pt						
☐ Continued						

Patient Health Care Concern ☐ Actual ☑ Potential	Date Resolved	Initials	Date Identified	Initials
Alteration in comfort: PAIN			7-16-04	

Patient Goal/Measurable Outcome	Date Identified	Initials
1. Patient will understand & utilize 1-10 scale method of quantifying pain	7-16-04	
2. Patient will understand the nature of pain and its treatment with analgesics	↓	↓
3. Patient will identify a comfort goal of _____ or patient will be free of pain.		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Discuss pain scale with patient. Assess and document with VS.	7-16-04					
2. Administer analgesics as ordered or per PRN sched	↓	↓				
3. Assess & evaluate effectiveness of analgesia with patient						
4. Discuss pain/analgesia regimen effectiveness with physician						
5. Assess for non-verbal pain expression in unconscious or intubated patients						
6. Discuss regimen effectiveness with physician						
7. Identify and discuss pain relief goals with patient						
☐ Continued						

Initials	Signature	Title	Initials	Signature	Title

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UHB IN SPACE BELOW

001172218
708320Q CMS 08-21-66
ROBERTSON, RICKY
300010686 44 MPU
I

INTERDISCIPLINARY PLAN OF CARE

DEPARTMENT OF
Medical Record Pilot Form 5091-11/96
The University of Texas Medical Branch Hospitals
Galveston, Texas

Patient Health Care Concern ☐ Actual ☑ Potential	Date Resolved	Initials	Date Identified	Initials
Alteration in nutrition			7-16-04	D

Patient Goal/Measurable Outcome	Date Identified	Initials
1. Patient will maintain adequate nutritional intake as recommended by Dietician	7-16-04	D
2. Patient will be free of signs of malnutrition; i.e. fatigue, anorexia, poor skin turgor	✓	✓
3. Patient's labs will reflect adequate nutrition; i.e. Albumin, Total Prot. Electrolytes WNL		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Assess pt. nutritional status upon admission	7-16-04	D				
2. Have Dietary consult within 24 hr of admit						
3. Begin diet, enteral feedings, or TPN within 24 hours of admission unless contraindicated.						
4. If NPO, consider enteral feeds or TPN						
5. Monitor Daily Weight for stability, monitor I&O						
6. Provide oral care and hygiene..						
7. Maintain route for enteral feeds on NPO patients	✓	✓				
☐ Continued						

Patient Health Care Concern ☐ Actual ☐ Potential	Date Resolved	Initials	Date Identified	Initials
Potential for self-harm R/T removal of lines and/or catheters				

Patient Goal/Measurable Outcome	Date Identified	Initials
1. Patient will not DC lines, catheters, ETT.		
2. Patient will regain onentation and ability to understand and comply with treatment while not causing self harm by discontinuing therapy.		
3.		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Assess for patient ability to understand & comply with treatment, ie not Dcing lines/catheters.						
2. Obtain and maintain order for restraints if needed						
3. Implement trial releases with observation when assessment indicates ability to safely comply						
4. Reassess need for restraints Q shift & PRN						
5. Reassess MSAOC & ability to understand and comply with therapy wihtout causing self-harm						
6. Use sedation and Analgesia as ordered/indicated						
7. Document pt data on Restraint flowsheet						
☐ Continued						

Initials	Signature	Title	Initials	Signature	Title
			D		NCT

* PATIENT ID CARD OR LABEL IS UNAVAILABLE. WRITE DATE, PT NAME AND UHI IN SPACE BELOW

INTERDISCIPLINARY PLAN OF CARE

DEPARTMENT OF

Medical Record Pilot Form 5091-11/96

The University of Texas Medical Branch Hospitals

Galveston, Texas

Orginal -Medical Record

Patient Health Care Concern	☐ Actual	☑ Potential	Date Resolved	Initials	Date Identified	Initials
Alteration in Tissue Perfusion					7-16-04	(A)

Patient Goal/Measurable Outcome	Date Identified	Initials
1. Maintain VS & in normal limits	7-16-04	(A)
2. Maintain normal ECG	7-16-04	(A)
3.		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Monitor VS q 2°	7-16	(A)				
2. Monitor ECG as ordered	↓	↓				
3. Full assmt q 4°	↓	↓				
4.						
5.						
6.						
7.						
☐ Continued						

Patient Health Care Concern	☐ Actual	☐ Potential	Date Resolved	Initials	Date Identified	Initials

Patient Goal/Measurable Outcome	Date Identified	Initials
1.		
2.		
3.		

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1.						
2.						
3.						
4.						
5.						
6.						
7.						
☐ Continued						

Initials	Signature	Title	Initials	Signature	Title
(A)	[signature]	ANST			

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68504

MFG. BY MOORE UTMB FORMS MANAGEMENT STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
7083200 CMS 08-21-66
ROBERTSON, RICKY
30001068644 MPU
I

INTERDISCIPLINARY PLAN OF CARE

Medical Record Form 5091-Rev. 6/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

071604

MICU-

10.34

Patient Health Care Concern ☐ Actual ☐ Potential	Date Resolved	Initials	Date Identified	Initials
Respiratory Failure or Impending Respiratory Failure			7/16/04	HN
Patient Goal/Measurable Outcome			Date Identified	Initials
1. Acceptable pulmonary mechanics			7/16/04	HN
2. SpO2, ABG's acceptable			7/16/04	HN
3. Respiratory rate, breathing pattern acceptable			7/16/04	HN

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Ventilatory Support	7/16/04	HN				
2. ET Tube suction prn	7/16/04	HN				
3. Pulmonary mechanics prn	7/16/04	HN				
4. Asses patient as needed including ABG's and Vital signs	7/16/04	HN				
5. Bipap						
6.						
7.						
☐ Continued						

Patient Health Care Concern ☐ Actual ☐ Potential	Date Resolved	Initials	Date Identified	Initials
Obstructive disorders				
Patient Goal/Measurable Outcome			Date Identified	Initials
1. SPO2 acceptable-no de-saturation or bradycardia				
2. Acceptable Vital signs				
3. Daytime sleepiness improves or resolves				

Plan of Action	Date Initiated	Initials	Date Revised	Initials	Date Complete or D/C	Initials
1. Cpap						
2. Bipap						
3. Oxygen titrated in prn						
4. Continuous pulse oximtery						
5. Maintain acceptable SPO2,ABG's & vital signs						
6.						
7.						
☐ Continued						

Initials	Signature	Title	Initials	Signature	Title
HN	HNguyen	CRT			

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER MM68504

IF PATIENT ID CARD OR LABELS UNAVAILABLE, WRITE DATE, PT NAME AND UHF IN SPACE BELOW

001752 CMS
7085200 RICKY
ROBERTSON MPU
3000106844
1

171604

INTERDISCIPLINARY PLAN OF CARE

Medical Record Form 5091-6/97
The University of Texas Medical Branch Hospita
Galveston, Texas

Patient: Robertson, Ricky 708320Q

UTMB
MICU Progress Note
The University of Texas
Medical Branch
Galveston, Texas

7/16/04 10:56 AM

		MICU Bed 5 Inpatient Note ICU day 1 Vent Day 1
		The patient was seen and examined with **Dr. Beary MD**
		History: 39 y/o WM with PMH of bipolar d/o, borderline personality d/o, and
		polysubstance abuse presented to ER from TCD after being found unresponsive in
		TDC at 2210 (7/15/04), with empy stare and axillary temp of 108 F, HR=100,
		BP=98/60, O2 sats=73%. Intubated secondary to hypoxia. In the ER pt. was
		nonresponsive to pain and with fixed dialated pupils with HR=130, BP=76/18, O2
		Sats=100% on FIO2=60%. Pt. had CT head and was volume resuscitated for
		hypotension. Pt. had TCA levels with no QRS prolongation and was started on HCO3.
		Pt. then developed severe hypotension with MAP 20-30 and was started on dopamine
		and levophed to titrate MAP to 60 and was transferred to the floor for further
		management. Pt. started on emperic cefepime 2 g and vancomycin 1 g after
		obtaining BCx.
		PMH: Bipolar D/o with depression
		SH: TDC inmate, PMH of ETOH and tob. use
		FH: NC
		ROS: unable to obtain
		PE in ER:
		VS: HR=125, BP=118/39 (on pressor), T=37.3, O2 sats =96% on 60% FIO2
		GE: on unresponsive
		neck: supple
		HEENT: pt nasally intubated pupils fixed and dialated
		CV: S1S2 normal, tachycardia, no murmurs
		Pul: decreased BS ant. right side inframammary region
		Abd: soft,NT/ND
		Ext: no pitting edema
		Skin: little excoriations on R. hand and forearm
		Neuro: no gag refles, no responding to stimuli
		Meds prior to admission: Lithium carbonate 600mg BID, chlorapromazine100mg BID,
		Benzytropine 2 mg BID, amantadine 100mg BID, nortriptyline 75 mg QPM, tyenlonol,
		Dantroline 100 mg x1

Intern/Resident Signature Molly Wathan, MD 08171

Form updated by J. Henderson on 3-17-04

10.36

Patient: Robertson, Ricky 708320Q

UTMB
MICU Progress Note
The University of Texas Medical Branch Galveston, Texas

7/16/04 10:56 AM

Overnight:

Current Meds: Protonix 40 mg IV BID, heparin 5000 mg SC Q8h, Levofloxacin 500 mg IV

Examination:

BP: 135/41 **P:** 126 **RR:** 36 **$T_{current}$:** 39.1 **T_{max}:** 37.5 °C

Vasopressors: none

In/Out: 648/800 over last 24 hours **Balance:** 0

Urine: over last 24 hours **Urine output= 0.0** cc per hour.

General:pt. intubated and mildly responsive

ABD:soft, NT/ND

EXTR:no pitting edema

HEENT:fixed dialated pupils

Neuro:no gag reflex, unable to access

Neck:supple

Lines:

Card:S1S2 n.; tachycardia

Nutrition:

Chest:

Vent Mode:PRVC **FiO_2:**80 **Rate:**16 **PEEP:**5 **V_t:**500

ABG 7.35/30/173/16 **on FiO_2** 100%

A-a Gradient= 503 **P/F Ratio** =173

Laboratory:

WBC 17.2 **Hgb** 12.8 **Platelets** 78 **Diff** 87.3/5.4

Na 137 **K** 3.2 **Cl** 111 **CO_2** 20 **BUN** 24 **Cr** 2.38 **Glu** 87 **AG** 6

Ca 7.6 **PO_4** .8 **Mg** 1.9=

Other Labs: ammonia-17; lactic acid=5.3; PT= 19.8, PT INR=1.8, PTT=50, T4=6.2

Li level=1.4, acetamino<10, salicylate<10, Benzo <16, barb<2, TCA=660,

amphetamines positive, fibrinogen=82, FDP=>20, D dimer>4.0

Secretions:

Intern/Resident Signature Molly Wortham, MD 08/71

Form updated by J. Henderson on 3-17-04

10 37

Patient: Robertson, Ricky 708320Q

UTMB
MICU Progress Note
The University of Texas Medical Branch Galveston, Texas

7/16/04 10:56 AM

ECG:

CXR: Patchy opacities in the right mid and lower lung may be pul. edema or pneumonia. The heart size is normal. The tip of the endotracheal tube is at the level of the clavicular heads.

CT head without contrast: No intracranial hemorrhage, edema, herniation, hydrocephalus or acute infarct is identified. The basal cisterns are open. No skull fracture is identified. Scant fluid is present in the maxillary and sphenoid sinuses. A right nasal tube is in place. No acute intracranial abnormality.

Assessment and Plan:

1. 1. AMS/hypotension- 39 y/o WM with no significant hx of bipolar d/o found unresponsive in TDC unit s/p intubation. Pt. with fever, no neck stiffness, negative kernigs. PT. with neg. CT of head, increased WBC, normal anion gap, mild non gap metabolic acidosis, increased lactic acid level, coagulopathic and with increased TCA levels. Diff DX: include drug overdosage (TCA) vs. meningitis vs. sepsis (secondary to CAP) vs. MI vs. PE. PT now with profound hypotension and on dopamine and levophed. WIll obtain Bl. cx., follow lactate levels. COntinue IV fluids, alkalinization, and antibiotics (vancomycin, levofloxacin, ceftriaxone. Pt. with APACHE II score of 33. Will consider xigris. Will obtain cardiac enzymes and D-Dimer. Start levenox 100 mg SC Q12. Following DIC panel.

2. Respiratory failure- Likely secondary to drug overdose vs. sepsis. Continue mechanical ventilation. WIll add lovenox after DIC panel and D-Dimer.

3. Hypotension-Likely secondary to drug overdose vs. sepsis vs. meningitis. continue IV fluids. PT. given 6L of fluid in ER. Also getting HCO3 in IVF for the elevated TCA levels.

Molly Warthan, MD #08171 **W. Beary #5464**

W. Beary MD

Intern/Resident Signature Molly Warthan, MD 08171

Form updated by J. Henderson on 3-17-04

10-39

Date	Time	Notes
7/16/04		ICU - Fellow On Call.
7:30 AM		Please see full H&P by Dr Moreva.
		Briefly, 37 Y male on antipsychotic treatment c chlorpromazine, lithium & amantadine brought to ED p being found hypothermic & unresponsive & was intubated nasally.
		OE: pt. nasally intubated & tachypneac, unresponsive. BP 110/70 ; P 125 R 32 T 38.5 Pupils dilated & sluggish very
		Heart tachy.
		Lungs coarse BS (B) & BS (R) crackles
		Abdomen: soft, NT.
		Extr access.
		Labs: Significant for leukocytosis c (L) shift.
	↑ TCA level 660	hypokalemia, hypophosphatemia & mixed metabolic / respiratory acidosis c ↑ lactic acid level.
CT. brain-ne		CXR: infiltrate (R) mid & low zones.
		A/P:
		Unresponsiveness in a 37Y ♂ c ↑ TCA level, hypothermia, & shock. ? sec. to drug overdose vs NMS vs sepsis.
		- Contin CMV, IVF, Abx,
		- Consider NG lavage / Charcoal to remove any residue.
		- Would d/w faculty potential benefit of APC, though septic picture is not obvious which would make him a less desirable candidate for it.
		Ricky Robertson 18099.

S - Subjective O - Objective A - Assessment P - Plan (1) Diagnostic (2) Therapeutic (3) Patient Education
Please sign each entry with status.

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68533

MFG. BY MOORE UTMB STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

Ricky Robertson.

PROGRESS NOTES

Medical Record Form 5300-Rev. 6/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

Date	Time	Notes
7/16/04 7:00AM		Procedure Note: OPERATOR: Dr SATTAR. - (R) Femoral Arterial Line: - Indications: BP monitoring. Shock. - Under full sterile precaution (R) femoral arterial line placed on first pass & capsulation. EBL: scc. Faroog Sattar, MD. IB0998.
7/16/04	0745	Vent update: PRVC, FiO2=65%, peep=+5 RR=16, VT=500. HNguyen CRT
7/16/04	930	Nutrition See Consult Section. — Carol Ann ROLD
7/16/04	1505	Intern Progress Note I spoke with Roy Robertson (pts brother) and his wife Samantha at 1445 to advise them of the status of pt. They were informed that the pts condition was rapidly deteriorating and that death was imminent (with little chance for meaningful recovery). F discussion offline, they called back and authorized DNR status and approval to withhold supportive care. With that approval, those instructions were followed out. [Roy Robertson (269) 683-2393] His mother was called earlier today by another physician and she denied all responsibility and authority in pt management. Andy Dang MD #08164

S - Subjective O - Objective A - Assessment P - Plan (1) Diagnostic (2) Therapeutic (3) Patient Education
Please sign each entry with status.

PROGRESS NOTES
Medical Record Form 5300-Rev. 6/03 (reverse)

10 of 12

Date	Time	Notes
7/16/04		Death Note
15:10		Called to evaluate Pt for no pulse / lack respiration. Found Pt pulseless, no resp auscultated after 30s, no heart sounds auscultated after 30s, Pupils fixed and dilated, no response to painful stimuli, Ø gag reflex, Ø Corneal reflex
		[signature] BIOE

S - Subjective O - Objective A - Assessment P - Plan (1) Diagnostic (2) Therapeutic (3) Patient Education
Please sign each entry with status.

ADDITIONAL FORMS MAY BE OBTAINED FROM MATERIALS MANAGEMENT REORDER NUMBER 68533

MFG. BY MOORE UTMB STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

001172218
7083200 CMS 08-21-66
ROBERTSON, RICKY
3000106844 MPU
I

PROGRESS NOTES

Medical Record Form 5300-Rev. 6/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record

10-41

Date: 07/16/04 Pt. Name: ROBERTSON ,RICKY UH#: 708320Q
ADMIT STATUS: FULL ADMIT CLINIC:
REQUEST FOR CONSULTATION: FOOD AND NUTRITION
PT TYPE: I FIN CLASS: T MG CARE: N INSURANCE: TDCJ STATE PRISONER
DSC STS: NONE Priority: ASAP
Account#: 30001068644 DOB: 08/21/1966 Room/Bed: J4A J4A 05
Adm Date/Time: 07/16/04 03:22 Age/Sex: 37 / M
Service/Team: MPU / MICU

Attend: 05464 BEARY MD,WILLIAM M Pager:
Resident: 07674 MOVVA MBBS,SUNIL
Intern:

To: FOOD FOOD AND NUTRITION Pager: Phone: 409-772-9777
From: 05464 BEARY MD,WILLIAM M Pager: Unit#: 409-772-4203
Y73C KHEDERLARIAN RN , BERTHA
History: ROBERTSON ,RICKY 708320Q MPU ANTICIPATED D/C DATE
37 C M 07/16/04
Diag: DSC STS: NONE

Reason: POSITIVE SCREEN CONSULT:
NUTRITIONAL RISK.OD PATIENT

NURSE STATION TELEPHONE NUMBER:
772 - 4203

CONSULT

Entered by: Y73C BERTHA KHEDERLARIAN ORDER #: 23
Entered Date/Time: 07/16/04 05:20
TO ANSWER CONSULT ON LINE SELECT ANSWER/DISPLY CONSULT ON PFUN MENU
CONSULT RESPONSE:

Problem: Pt intubated + NPO x today.
Evaluation: RST Ht: 6'2" wt: 104kg @ 121% IBW
ABW: 91kg NS @ 50ml/° meds: protonix
ø dht placed yet

WRITTEN BY: Carol Lee RDN DATE: 7/16/04 TIME: 9 :45
SERVICE: FNS EXT#: PAGER: 6452033
THE UNIVERSITY OF TEXAS MEDICAL BRANCH HOSPITALS - GALVESTON, TEXAS
REQUEST FOR CONSULTATION - MEDICAL RECORD FORM 5411-11/96
OECNE3FA
ORIGINAL - MEDICAL RECORD

1042

Date: 07/16/04 Pt. Name: ROBERTSON ,RICKY UH#: 708320Q
Account#: 30001068644 Room/Bed: J4A J4A 05

REQUEST FOR CONSULTATION: FOOD AND NUTRITION

Con't Consult Response:

(7/16) 137 | 111 | 24 / 87 Phosphorus 0.8↓
3.2 | 20 | 2.36

Goal: ① Meet ≥ 75% est ntr needs.
② Maintain hydration.
③ Electrolyte balance + renal fxn wnl

Plan: ① Rec place enteral feeding tube.
② Suggest Jevity 1.2 @ 80 ml/° goal rate (2304 kcal, 107 gm protein, 42 gm fiber, + 1546 ml H_2O) when renal fxn return to normal
③ Suggest 150 ml H_2O bolus fluids q 3° when pt at goal rate. Provide additional ~~Increase~~ fluids as pt transitions to goal rate.
④ Start at 10 ml' then ↑ 10 ml q 4-6° as tol.
⑤ Watch for s/sx of tf intolerance, check residuals + keep HOB > 30°.
⑥ Do not keep NPO > 3-5 days.
⑦ will flu q 2x per wk.
⑧ If pt ↓ renal fxn suggest Osmolite @ 85 ml/° + 125 ml H_2O bolus q 3°.

Est ntr needs: 2275-2730 kcal (25-30 kcal/kg), 55-73 gm protein (0.6-0.8 gm/kg) or 73-91 gm protein (0.8-1.0 gm/kg if renal fxn wnl) and 2700 ml fluids (30 ml/kg)

WRITTEN BY: _____ DATE: ___/___/___ TIME: __ : ___ __

SERVICE: _____ EXT#: _____ PAGER: _____

THE UNIVERSITY OF TEXAS MEDICAL BRANCH HOSPITALS - GALVESTON, TEXAS
REQUEST FOR CONSULTATION - MEDICAL RECORD FORM 5411-11/96
OECNE5FA
ORIGINAL - MEDICAL RECORD

CONSULT

1043

Patient Account: 30001068-644
Med. Rec. No.: **(0000)708320Q**
Patient Name: **ROBERTSON, RICKY**
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

UTMB
University of Texas Medical Branch
Galveston, Texas 77555-0543
(409) 772-1238
Fax (409) 772-5683

Discharge Summary

HEME-COAG

HEMATOPATHOLOGY EXT 22249

	COLLECTION DATE:	07/16/04	07/16/04
	COLLECTION TIME:	0110	0500

PROCEDURE	REFER RANGE	UNITS		
WBCx10^3	[4.5-10.5]	/CMM	**17.2H**	**20.5H**
RBCx10^6	[4.25-5.65]+	/CMM	4.33f	4.35
HGB	[13.5-17.0]+	G/DL	**12.8Lf**	**13.1L**
HCT	[37.0-50.0]+	%	**36.8Lf**	37.0
MCV	[82.0-97.0]	FL	85.0	85.1
MCH	[27.0-33.0]	PG	29.6	30.1
MCHC	[31.0-36.2]	%	34.8	35.4
RDW	[11.8-14.1]	%	13.4	12.8
PLTx10^3	[150-400]	/CMM	**78L**	**83L**
MPV	[7.8-11.2]	FL	10.8	**12.3H**

07/16/04 0110 RBCx10^6
REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323.
NORMAL LOW FROM 3.90 TO 4.25. NORMAL HIGH FROM 4.95 TO 5.65.
RESULT FLAG NOT CHANGED.
FOOTNOTE ADDED ON 07/16/04 AT 0323 BY LAB187

07/16/04 0110 HGB
REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323.
NORMAL LOW FROM 11.5 TO 13.5. NORMAL HIGH FROM 15.5 TO 17.0.
RESULT FLAG FROM TO L.
FOOTNOTE ADDED ON 07/16/04 AT 0323 BY LAB187

07/16/04 0110 HCT
REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323.
NORMAL LOW FROM 34.0 TO 37.0. NORMAL HIGH FROM 45.0 TO 50.0.
RESULT FLAG FROM TO L.
FOOTNOTE ADDED ON 07/16/04 AT 0323 BY LAB187

DIFFERENTIAL - MANUAL

SEGS	[45-78]	%	74
BANDS	[0-8]	%	**19H**
LYMPHS	[20-51]	%	**5L**
META	[0-2]	%	1
MYELO	[< 0]	%	**1H**
NRBC/100WB	[< 0]		**2H**
#CELS CNTD			100

DIFFERENTIAL MORPHOLOGY

POLYCHROM		2+	2+

DIFFERENTIAL - AUTOMATED

GRAN%	[45.0-78.0]	%	**87.3H**
LYMPH%	[20.0-51.0]	%	**5.4L**
MONO%	[4.0-12.0]	%	6.6

Legend:
L = Low, H = High, f = Footnote, + = Admit Record Chng

Medical Record Copy
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Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

UTMB
University of Texas Medical Branch
Galveston, Texas 77555-0543
(409) 772-1238
Fax (409) 772-5683

Discharge Summary

HEME-COAG

HEMATOPATHOLOGY EXT 22249

PROCEDURE	REFER RANGE	UNITS	COLLECTION DATE: 07/16/04 COLLECTION TIME: 0110	07/16/04 0500
DIFFERENTIAL - AUTOMATED				
EOS%	[0.0-6.0]	%	0.5	
BASO%	[0.0-2.0]	%	0.2	
GRAN#x10^3	[2.1-7.4]	/CMM	**15.0H**	
LYMP#x10^3	[1.3-4.4]	/CMM	**0.9L**	
MONO#x10^3	[0.2-0.9]	/CMM	**1.1H**	
EOS#x10^3	[0.0-0.4]	/CMM	0.1	
BASO#x10^3	[0.0-0.2]	/CMM	0.0	
IMM GRAN			**OBSERVED***	

COAGULATION

PROCEDURE	REFER RANGE	UNITS	COLLECTION DATE: 07/16/04 COLLECTION TIME: 0110	07/16/04 0500
PROTIME PA	[10.5-13.9]	SEC	**19.8H**	**28.7H**
PT INR			1.8	2.7
APTT MN NM		SEC	28	28
APTT PATNT	[22-34]	SEC	**50H**	**102C**
FIBRINOGEN	[200-400]	MG/DL		**82Cf**
FDP	[<5]	UG/ML		**>20***
FDP TYPE				PLASMA
D DIMER	[< .55]			> 4.0f

07/16/04 0500 FIBRINOGEN CRITICAL VALUES (APTT/FIBRINOGEN) CALLED TO EVELYN AT 07/16/04 07:19/LT./READBACK VERIFIED BY LT.

D DIMER (08/23/00 -- Current)
RESULTS ARE REPORTED IN uG FEU/ml. FEU = FIBRINOGEN EQUIVALENT UNITS.

Legend:
L = Low, H = High, C = Critical, * = Abnormal, f = Footnote

Medical Record Copy
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Patient Name: ROBERTSON, RICKY
Med. Rec. No.: (0000)708320Q
Patient Location: J4A - 05
Printed Date / Time: 07/24/04 - 0002
Page: 2

Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

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Discharge Summary

CHEMISTRY EXT 29227

PROCEDURE	REFER RANGE	UNITS	COLLECTION DATE: 07/16/04 COLLECTION TIME: 0030	07/16/04 0110	07/16/04 0500
NA	[135-145]	MMOL/L		137	137
K	[3.5-5.0]	MMOL/L		**3.2L**	4.1f
CL	[98-108]	MMOL/L		**111H**	**112H**
CO2 TOTAL	[23-31]	MMOL/L		**20L**	**19L**
AGAP	[2-16]			6	6
BUN	[7-23]	MG/DL		**24H**	**26H**
GLUCOSE	[70-110]	MG/DL		87	**129H**
CREATININE	[0.70-1.70]	MG/DL		**2.38H**	**1.89H**
BUN/CREAT				10.1	13.8
IONIZED CA	[4.50-5.30]	MG/DL			4.66
PH SERUM	[7.34-7.45]				**7.22L**
CALCIUM	[8.6-10.6]	MG/DL		**7.6L**	**7.5L**
PHOSPHORUS	[2.5-5.0]	MG/DL		**0.8Cf**	**1.4L**
MAGNESIUM	[1.7-2.4]	MG/DL		1.8	1.7
TROPONIN I	[0.00-1.00]	ng/mL			**16.01H**
AMMONIA	[9-33]	UMOL/L		17	
LACT ACID	[0.3-2.6]	MMOL/L	**5.3Cf**		**5.2Cf**

CHEMISTRY

ENZYMES

PROCEDURE	REFER RANGE	UNITS	COLLECTION DATE: 07/16/04 COLLECTION TIME: 0500
CK	[33-194]	U/L	**7748H**
CK-MB	[< 5.0]	ng/mL	**63.7H**
CKMB INDEX	[0.0-2.5]	%	0.8

CKMB INTER 07/16/04 0500 INCREASED CK AND MB WITH NORMAL %MB SUGGESTS STRIATED MUSCLE INJURY WHICH CAN MASK MYOCARDIAL MUSCLE INJURY.

Legend:
L = Low, H = High, C = Critical, f = Footnote

K..... 07/16/04 0500 SLIGHT HEMOLYSIS PRESENT
PHOSPHORUS..... 07/16/04 0110 CRITICAL VALUE(S) CALLED TO HEATHER ON 07/16/04 01:50 BY LAB217 AND READBACK.
LACT ACID..... 07/16/04 0030 PANIC RESULT CALLED TO EMILY AT 07/16/04 02:42/REPEATED

LACT ACID..... 07/16/04 0500 CRITICAL VALUE(S) CALLED TO EVELYN ON 07/16/04 09:01 BY 429 AND READBACK.

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Continued...

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Patient Account: 30001068-644
Med. Rec. No.: **(0000)708320Q**
Patient Name: **ROBERTSON, RICKY**
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

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Discharge Summary

URINALYSIS EXT 23196

COLLECTION DATE: 07/16/04
COLLECTION TIME: 0500

PROCEDURE	REFER RANGE	UNITS	
COLOR			**Amber***
APPEARANCE			Clear
SP GRAVITY	[1.003-1.030]		1.010
PH	[4.8-8.0]		8.0
PROTEIN	[NEGATIVE]		**100mg/dL***
GLU U QUAL	[NEGATIVE]		NEGATIVE
KETONES	[NEGATIVE]		NEGATIVE
BILIRUBIN	[NEGATIVE]		NEGATIVE
BLOOD	[NEGATIVE]		**250/uL***
UROBILIN	[0-1mg/dL]		1 mg/dL
NITRITE	[NEGATIVE]		NEGATIVE
LEUK ESTER	[NEGATIVE]		NEGATIVE
RBC/HPF	[0-3]	/HPF	**21H**
WBC/HPF	[0-5]	/HPF	0
BACTERIA	[NEGATIVE]		**FEW***

URINALYSIS
TDM

THERAPEUTIC DRUGS EXT 29227

COLLECTION DATE: 07/16/04 07/16/04
COLLECTION TIME: 0030 0110

PROCEDURE	REFER RANGE	UNITS		
LITHIUM		MMOL/L	**1.4Cf**	

LITHIUM (05/09/02 -- Current)
THERAPUTIC RANGE: 0.6-1.2 MMOL/L
TOXIC: GREATER THAN 1.2 MMOL/L

LITHIUM TL	HOURS	N/A	
ACETAMINOP	ug/mL		**<10***

ACETAMINOP (03/23/04 -- Current)
THERAPEUTIC RANGE: 10-30 ug/mL
TOXIC: GREATER THAN 200 ug/mL @ 4 HOUR POST INGESTION
OR
GREATER THAN 50 ug/mL @ 12 HOUR POST INGESTION

ACETAMIN T	HOURS	**N/A***
SALICYLATE	mg/L	**<10***

SALICYLATE (03/23/04 -- Current)
THERAPEUTIC RANGE FOR ANALGESIC AND ANTIPYRETIC USE: 20-100 mg/L
THERAPEUTIC RANGE FOR ANTI INFLAMATORY USE: 100-250 mg/L
TOXIC RANGE: GREATER THAN 300 mg/L

SALICYLATE	HOURS	**N/A***

Legend:
H = High, C = Critical, * = Abnormal, f = Footnote
LITHIUM..... 07/16/04 0030 PANIC RESULT CALLED TO EMILY AT 07/16/04 02:41/REPEATED

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Cont. [illegible]

10.4-7

Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

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Discharge Summary

CHEMISTRY

TOXICOLOGY EXT 29227

COLLECTION DATE: 07/16/04
COLLECTION TIME: 0110

PROCEDURE	REFER RANGE	UNITS	
BENZO S		NG/ML	<16f
BARB S		UG/ML	<2f
TRICYCLIC		NG/ML	660f

TOXICOLOGY DRUG SCREEN

DATE/TIME	PROCEDURE	RESULTS	THRESHOLD	
07/16/04 0110				
	AMP METH	PRESUMPTIVE POSITIVE	SCREEN CUTOFF:	1000 NG/ML
	COC MET	NEGATIVE	SCREEN CUTOFF:	300 NG/ML
	OPIATES	NEGATIVE	SCREEN CUTOFF:	300 NG/ML
	THC	NEGATIVE	SCREEN CUTOFF:	50 NG/ML

TOXICOLOGY

SPECIAL CHEMISTRY EXT 29227

COLLECTION DATE: 07/16/04
COLLECTION TIME: 0110

PROCEDURE	REFER RANGE	UNITS	
T4 TOTAL	[4.7-11.4]	MCG/DL	6.2

T4 TOTAL (Initial -- Current)
NORMAL RANGE OR EXPECTED VALUES WILL VARY FOR PATIENTS WHO ARE ON OVULATION CONTROL DRUGS OR PREGNANT.

Legend:
f = Footnote
BENZO S (Initial -- Current)
SERUM RESULTS OBTAINED USING IMMUNOASSAY DO NOT RULE OUT USE OF ALL DRUGS IN A DRUG GROUP DUE TO VARYING CROSS-REACTIVITY WITH THE ANTIBODY.
BARB S (Initial -- Current)
SERUM RESULTS OBTAINED USING IMMUNOASSAY DO NOT RULE OUT USE OF ALL DRUGS IN A DRUG GROUP DUE TO VARYING CROSS-REACTIVITY WITH THE ANTIBODY.
TRICYCLIC (10/16/01 -- Current)
THE FOLLOWING GUIDELINES ARE RECOMMENDED:
A TOTAL CONCENTRATION GREATER THAN OR EQUAL TO 200 NG/ML FOR DOXEPIN AND METABOLITE OR GREATER THAN OR EQUAL TO 400 NG/ML FOR AMITRIPTYLINE, IMIPRAMINE AND METABOLITES MAY INDICATE TOXICITY AND REQUIRE QUANTITATION BY HPLC.
OTHER DRUGS/COMPOUNDS MAY CROSS-REACT WITH THE TCA ANTIBODY.

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Continued...

10 46

Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
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Discharge Summary

MICROBIOLOGY - BLOOD CULTURES

EXTENSION: 21738

BLOOD CULTURE — ACCESSION # BC-04-13134 — COLLECT DATE: 07/16/04 0030
SOURCE: VENOUS BLOOD — RECEIVE DATE: 07/16/04 0938
START DATE: 07/16/04 0938

FINAL REPORT:
07/23/04 2000
NO ORGANISMS ISOLATED

BLOOD CULTURE — ACCESSION # BC-04-13135 — COLLECT DATE: 07/16/04 0030
SOURCE: VENOUS BLOOD — RECEIVE DATE: 07/16/04 0938
START DATE: 07/16/04 0938

FINAL REPORT:
07/23/04 2000
NO ORGANISMS ISOLATED

BLOOD CULTURE — ACCESSION # BC-04-13138 — COLLECT DATE: 07/16/04 0530
SOURCE: VENOUS BLOOD — RECEIVE DATE: 07/16/04 0946
LT HAND PIV — START DATE: 07/16/04 0946

FINAL REPORT:
07/23/04 2000
NO ORGANISMS ISOLATED

BLOOD CULTURE — ACCESSION # BC-04-13139 — COLLECT DATE: 07/16/04 0530
SOURCE: VENOUS BLOOD — RECEIVE DATE: 07/16/04 0946
LT ARM — START DATE: 07/16/04 0946

FINAL REPORT:
07/23/04 2000
NO ORGANISMS ISOLATED

MICROBIOLOGY - URINE CULTURES

EXTENSION: 21738

URINE CULTURE — ACCESSION # 04-198-1978 — COLLECT DATE: 07/16/04 0630
SOURCE: URINE, CATHERIZED — RECEIVE DATE: 07/16/04 1129
START DATE: 07/16/04 1129

FINAL REPORT:
07/17/04 0713
NO AEROBIC ORGANISMS ISOLATED

MICROBIOLOGY

Continued...

Medical Record Copy
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Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
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Discharge Summary

ACUTE CARE

BLOOD GASES

EXTENSION: 21886

			COLLECTION DATE:	07/16/04	07/16/04	07/16/04	07/16/04
			COLLECTION TIME:	0031	0520	0916	0947
PROCEDURE	REFER RANGE	UNITS					
PH ART	[7.35-7.45]			7.35	**7.19C**	**7.28L**	**7.25L**
PCO2 ART	[35-45]	MM/HG		**30L**	**49H**	**32L**	**32L**
PO2 ART	[80-100]	MM/HG		**173H**	**57L**	**71L**	86
HCO3 ART	[22-26]	MEQ/L		**16Cf**	**18C**	**14C**	**13C**
			07/16/04 0031 CRITICAL VALUE(S) CALLED TO RT ON 07/16/04 00:48 BY LAB2117 AND READBACK.				
			07/16/04 0916 TC 40.2				
			07/16/04 0947 TC 40.5				
THB ART	[13.5-18.0]	G/DL			14.8		16.1
%O2HB ART	[94.0-99.0]	%			**81.2L**		**91.7L**
%COHB ART	[0.0-1.5]	%			0.2		0.1
%COHB ART (Initial -- Current)							
			RANGE FOR 00MIN TO 150 YRS: LESS THAN 1.5% FOR NON-SMOKERS				
			1.5 - 5.0% FOR SMOKERS				
%METHB ART	[0.4-1.5]	%			1.1		1.2
VOL%O2 ART	[15.0-23.0]	%			16.9		20.7
PH VEN	[7.32-7.42]						**7.20C**
PCO2 VEN	[41-51]	MM/HG					46
PO2 VEN	[25-40]	MM/HG					39
HCO3 VEN	[24-28]	MEQ/L					**17C**
THB VEN	[13.5-18.0]	G/DL					16.4
%O2HB VEN	[52.0-63.0]	%					**48.8L**
%COHB VEN	[0.0-1.5]	%					0.2
%METHB VEN	[0.4-1.5]	%					0.9
VOL%O2 VEN	[6.0-12.0]	%					11.2
NA	[135-153]	MEQ/L			141		
K+	[3.5-5.0]	MEQ/L			**3.2L**		
AC CA IONZ	[4.50-5.30]	MG/DL			4.70		
GLUCOSE	[70-115]	MG%			88		

Legend:
L = Low, H = High, C = Critical, f = Footnote

Medical Record Copy
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Continued...

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Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS *Sex:* M *Race:* C
Admitting Dr.: BEARY MD,WILLIAM M
Ordering Dr.: BEARY MD,WILLIAM M
Location: JOHN SEALY TOWER 4A

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Galveston, Texas 77555-0543
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Discharge Summary

CANCELLATIONS

PROCEDURE:	REASON:	DATE/TIME:		CANCEL TECH:
THYROID STIMULATING HORMONE	HEMOLYZED	07/16/04	0110	LAB2117
PHOSPHORUS SERUM	HEMOLYZED	07/16/04	0110	LAB2117
CALLED KAREN AT 07/16/04 01:24 SAMPLES	HEMOLYZED. LAB2117			
CKMB	HEMOLYZED	07/16/04	0110	LAB2117
MAGNESIUM SERUM	HEMOLYZED	07/16/04	0110	LAB2117
KETONE, SERUM	HEMOLYZED	07/16/04	0110	LAB2117
TROPONIN I	HEMOLYZED	07/16/04	0110	LAB2117
BASIC METABOLIC PANEL (80048)	HEMOLYZED	07/16/04	0110	LAB2117
HEPATIC FUNCTION PANEL (80076)	HEMOLYZED	07/16/04	0110	LAB2117

CANCELLATION

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FALL PREVENTION ASSESSMENT: √ each risk factor present for this patient

- ☐ Age over 75
- ☑ Currently in the ICU
- ☐ Agitation/confusion/impaired memory/impaired judgement/delirium/dementia
- ☐ ETOH abuse/withdrawal
- ☑ Unable or unwilling to follow directions
- ☐ Prior history of falls
- ☐ Dizziness, vertigo
- ☐ Frequent need to toilet/incontinence
- ☐ Orthostasis/hypovolemia

Other

- ☐ _____
- ☐ _____

If ANY of the above boxes are √'d (in behavioral medicine, any two boxes) this patient is ***at risk*** for falls. The FALL PREVENTION PLAN OF CARE MUST BE IMPLEMENTED (available on POE and frequently used forms)

- ☐ Anesthesia in past 24 hours
- ☐ Anticonvulsants/antidepressants/ tranquilizers/hypnotics/sedatives
- ☐ Antihypertensives/diuretics/laxatives
- ☐ Eye drops
- ☐ Depression
- ☐ Muscle weakness or paralysis
- ☑ Restricted by tubing/equipment (IV, NGT, Foley, etc)
- ☐ Unsteady gait/Uses cane or walker/Requires assistance for ambulating
- ☐ History of seizures/neurological diagnosis
- ☐ Uncorrected poor vision
- ☐ Decreased hearing
- ☐ Decreased sensation
- ☐ Communication impairment

Other

- ☐ _____
- ☐ _____

If TWO OR MORE of the above boxes are √'d (in behavioral medicine, any three boxes) this patient is ***at risk*** for falls. The FALL PREVENTION PLAN OF CARE MUST BE IMPLEMENTED (available on POE and frequently used forms)

- ☐ Patient not at risk for falls

Assessed by: V V RN Date: 7-16-04 Time: 0420

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE OF BIRTH AND LAST NAME ON SPACE BELOW

001172218
708320Q CMS 08-21-66
ROBERTSON ,RICKY
300010686 44 MPU
I

FALL PREVENTION ASSESSMENT

Medical Record Form 5310S-Page 1- 04/03
The University of Texas Medical Branch Hospit
Galveston, Texas

Original-Medical Record

FALL PREVENTION PLAN OF CARE: √ all fall precautions initiated for this patient

- [x] Fall prevention sign on door (except ICU/behavioral medicine)
- [x] Fall prevention (green) armband on patient

Bed/Call Light

- [ ] Bed in low position
- [ ] Bed wheels locked
- [ ] Call light in reach
- [ ] Bed exit alarm activated
- [x] Side rails up x 4

Communication

- [ ] Communication board
- [ ] Note pad and pen in reach

Consults/Positive Screens

- [ ] Physical Therapy Date: _____ Time: _____ Received by: _____
- [ ] Speech Therapy Date: _____ Time: _____ Received by: _____

Education

- [ ] Family and patient about fall precautions in hospital
- [ ] Family and patient about fall precautions in home
- [ ] Activity restrictions

Hearing

- [ ] Hearing device in place, on and working

Immediate environment

- [ ] Minimum equipment in room
- [ ] Room tidy
- [ ] Pathway to bathroom free of obstacles

Medical condition

- [ ] Orthostatic blood pressure checks q ___ hrs

Mobility

- [ ] Bedside commode
- [ ] Minimum number of helpers to get up = ___
- [ ] Gait belt when up
- [ ] Non-skid shoes or slippers
- [ ] Cane, walker, wheelchair for mobility

Room

- [x] Bathroom light on
- [ ] Room near nurse's station
- [ ] Room door/window blinds open at all times

Toileting

- [ ] Bedside commode
- [ ] Toileting schedule q ___ hrs

Vision

- [ ] Glasses within reach
- [ ] Nightlight after dark

Other

- [ ] Visual check q ___ min/hrs (circle)
- [ ] Patient Safety Assistant
- [ ] Let family/companion accompany patient to tests and treatments
- [ ] _____

Implemented by: [signature] RN Date: 7-16-04 Time: 0420

IF PATIENT CARE IS UNAVAILABLE WRITE DATE FT NAME AND UNIT IN SPACE BELOW

FALL PREVENTION PLAN OF CARE

Medical Record Form 5310S-Page 2 -04/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

1053

	Evaluator's Name		Date of Assessment 7-16			
Sensory perception Ability to respond meaningfully to *pressure-related* discomfort	**1. Completely limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to *diminished level of consciousness* or sedation. OR limited ability to feel pain over most of body surface	**2. Very limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of the body.	**3. Slightly limited:** Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	1			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2 Moist** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist:** Skin is occasionally moist requiring an extra linen change approximately once a day.	**4. Rarely moist** Skin is usually dry, linen requires changing only at routine intervals.	3			
Activity Degree of physical activity.	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each day in bed or chair.	**4. Walks frequently** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	1			
Mobility Ability to change and control body position	**1. Completely immobile:** Does not make even slight change in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	1			
Nutrition Usual food intake pattern	**1. Very poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV for more than 5 days.	**2. Probably inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplement.	1			
Friction and shear	**1. Problem:** Requires moderate to maximum assistance in moving. Completes lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		1			
[1]NPO: Nothing by mouth. [2]IV: Intravenously. [3]TPN: Total parenteral nutrition Source: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission JN98055/2-Rev. 7/93 Form 5642- 7/21/94				**Total score**	8			

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Braden Scale for Predicting Pressure Sore Risk

Medical Record Form No. 5642 - Rev. 07/21/1994

The University of Texas Medical Branch Hospitals
Galveston Texas

Original - Medical Record